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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08420

08424

CERTIFICATE OF DEATH

Reg. Dist. No.

96

| | | | |
|--|------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Principio Furnace | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Principio Furnace | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 7 | | d. STREET ADDRESS Route 7 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph W. Abrahams Jr. | | 4. DATE OF DEATH Month Day Year Aug. 23 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 16, 1908 |
| 9. AGE (In years last birthday) 49 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | | 10c. KIND OF BUSINESS OR INDUSTRY Aberdeen P. Ground. Mexico | |
| 11. BIRTHPLACE (State or foreign country) U S A | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Joseph W. Abrahams | | 14. MOTHER'S MAIDEN NAME Catherine Ortiz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-07-1129 | |
| 17. INFORMANT Address Lydia W. Abrahams, Principio Furnace, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X Bronchogenic Carcinoma DUE TO with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — | | INTERVAL BETWEEN ONSET AND DEATH 9 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 1st, 1957, to Aug. 23rd, 1957, that I last saw the deceased alive on Aug. 23rd, 1957, and that death occurred at 3 P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edward C. Froom, M.D. | | ADDRESS (Street, city or town, state) 211 North Union Ave. DATE SIGNED 8/23/57 | |
| PHYSICIAN'S NAME (Type) Edward C. Froom, M.D. Havre de Grace, Ind. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-26-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Hopewell | | 22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son | | ADDRESS Perryville, Md. | |
| 24a. REC'D BY REGISTRAR DATE 8-24-1957 | | 24b. REGISTRAR'S SIGNATURE Irene E. Dougherty | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

AUG 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

08425

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08421

Reg. Dist. No.

| | | | | | | |
|---|------------------------------|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo, R.D. | | c. LENGTH OF STAY IN 1b all life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | d. STREET ADDRESS / | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Vernon Middle David Last ABSHER | | | 4. DATE OF DEATH Month 8 Day 8 Year 19 57 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-27-43 | | 9. AGE (In years last birthday) 13 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY High School | | 11. BIRTHPLACE (State or foreign country) Street, Md. | | |
| 13. FATHER'S NAME William Walter Absher | | | 14. MOTHER'S MAIDEN NAME Martha Elvira Barker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. / | | 17. INFORMANT Address William Walter Absher, Conowingo, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest and head fracture neck and fractured right clavicle DUE TO 9/2.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) right clavicle DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Farm Tractor turned over on him | | | | |
| 20c. TIME OF INJURY Month, Day, Year 7.15 o. m. 8-8-57 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm | | |
| 20f. (City or town) Conowingo | | 20g. (County) Cecil | | 20h. (State) Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | |
| ACTUAL SIGNATURE R.C. Dodson | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8-9-57 | | |
| EXAMINER'S NAME (Type) R.C. Dodson | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-11-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baptist Cemeyery Conowingo | | |
| 22d. LOCATION (City, town, or county) Conowingo, Cecil Md. | | 22e. REC'D BY REGISTRAR Aug 12 57 | | 22f. REGISTRAR'S SIGNATURE R. E. Beach | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson P. Kingdon Md. | | | | | | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

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| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWNSON | |
| c. LENGTH OF STAY IN 1b 32yrs 1mo. 7days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 31 Willow Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle (NMI) Last ACKERMAN | | 4. DATE OF DEATH Month August Day 3 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 8, 1875 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Door & Sash Mfg. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Peace Time | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Hospital Records, VAH., Perry Point, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL, UNRESOLVED 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491 (b) PYELONEPHRITIS, BILATERAL, SEVERE DUE TO (c) PROSTATIC HYPERTROPHY, BENIGN | | INTERVAL BETWEEN ONSET AND DEATH 5 to 4 Days Unknown Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. VA p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 27, 1925 , to August 3, 1957 , that he was the deceased and that death occurred at 11: P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Maryland DATE SIGNED 8-4-57 | | | |
| ACTUAL SIGNATURE E.S. Ellis, | | M.D. V.A. Hospital, Perry Point, Md. | |
| PHYSICIAN'S NAME (Type) E.S. ELLIS, M.D., Acting Director, Professional Services, VA Hospital | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF 8-4-57 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son | | ADDRESS Havre DeGrace, Md. | |
| 24a. REC'D BY REGISTRAR DATE 8-7-57 | | 24b. REGISTRAR'S SIGNATURE Inez E. Dougherty | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Death | | Place of Death | | Cause of Death | |
| Occupation | | Manner of Death | | Signature of Physician | |
| Signature of Registrar | | Date of Registration | | Place of Registration | |

| | | | | | |
|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Death | | Place of Death | | Cause of Death | |
| Occupation | | Manner of Death | | Signature of Physician | |
| Signature of Registrar | | Date of Registration | | Place of Registration | |

| | | | | | |
|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Death | | Place of Death | | Cause of Death | |
| Occupation | | Manner of Death | | Signature of Physician | |
| Signature of Registrar | | Date of Registration | | Place of Registration | |

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08416

CERTIFICATE OF DEATH

08423

Reg. Dist. No. 92

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | | c. LENGTH OF STAY IN 1b 52 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 North East | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Julius Middle J Last Baer | | | | 4. DATE OF DEATH Month August Day 31 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 15, 1882 | | 9. AGE (In years last birthday) yrs. 75 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking | | 11. BIRTHPLACE (State or foreign country) Batavia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harry Baer | | | | 14. MOTHER'S MAIDEN NAME Rosie Walcott | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-22-1533 | | 17. INFORMANT Union Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism and right hemiplegia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 48 hours 7 weeks | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 10 , 19 57 to Aug. 31 , 19 57 , that I last saw the deceased alive on August 31 , 19 57 , and that death occurred at 5:25 p. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE S. Ralph Andrews, Jr. | | M.D. 233 E. Main Street | | ADDRESS (Street, city or town, state) | | DATE SIGNED 8/31/57 | |
| PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | | Elkton, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept 1, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery | | 22d. LOCATION (City, town, or county) (State) Coatesville, Chester Co., Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant | | ADDRESS North East, Maryland | | 24a. REC'D BY REGISTRAR DATE 9/2/57 | | 24b. REGISTRAR'S SIGNATURE JR Fraser | |

BUREAU V. S.

SEP 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

08417

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08424

Reg. Dist. No. 92

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | c. LENGTH OF STAY IN 1b <u>3 minutes</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Charlestown</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u> | | | | d. STREET ADDRESS <u>1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>M</u> Last <u>Boyer</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>19 57</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6 -8-1915</u> | |
| 9. AGE (In years last birthday) <u>42</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Theodore T Reed</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rosanna Rice</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Harvet A Boyer, Jr. Charlestown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> stating the underlying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>R.C. Dodson</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>R.C. Dodson</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-2-57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8-5-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Principio Md.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Principio Cecil. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant North East, Maryland</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>8/3/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>FR Frazier</u> | |

RECEIVED

AUG 6 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08427

CERTIFICATE OF DEATH

08425

Reg. Dist. No. 96

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS Conway & Greene Streets | |
| 3. NAME OF DECEASED (Type or print) WESLEY | | 4. DATE OF DEATH Month August Day 2 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 17, 1925 |
| 9. AGE (In years last birthday) 32 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME David Cheeseboro | | 14. MOTHER'S MAIDEN NAME Lou Jane Bobbitt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 300.2 DUE TO SCHIZOPHRENIC REACTION, CATATONIC TYPE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ATHRO SCLEROSIS, GENERALIZED, MODERATELY SEVERE. | | INTERVAL BETWEEN ONSET AND DEATH 6 to 8 Mon. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Autopsy on body only. Permission for Head refused. | | 20c. 300.2 SCHIZOPHRENIC REACTION, CATATONIC TYPE. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that VA attended the deceased from May 17 , 19 56 , to August 2 , 19 57 . XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX and that death occurred at 9:12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Maryland DATE SIGNED 8-4-57 | | | |
| ACTUAL SIGNATURE E. S. Ellis, M.D. Perry Point, Maryland | | | |
| PHYSICIAN'S NAME (Type) E. S. ELLIS, M.D., Acting Director, Professional Services, VA Hospital | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 8-4-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Not buried | | 22d. LOCATION (City, town, or county) (State) Balto - Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE KATIE R. WILLIAMS | | 24a. REC'D BY REGISTRAR 7-57 Irene E. Dougherty | |
| ADDRESS Baltimore, Maryland | | 24b. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED JOHN J. JOHNSON | | 2. SEX Male | | 3. AGE 45 | |
| 4. PLACE OF BIRTH Baltimore, Maryland | | 5. OCCUPATION Salesman | | 6. MARITAL STATUS Married | |
| 7. DATE OF DEATH August 1, 1957 | | 8. TIME OF DEATH 10:30 AM | | 9. PLACE OF DEATH Home | |
| 10. CAUSE OF DEATH Myocardial Infarction | | 11. MANNER OF DEATH Natural | | 12. SIGNATURE OF PHYSICIAN J. H. Smith, M.D. | |
| 13. SIGNATURE OF REGISTRAR A. B. Jones | | 14. SIGNATURE OF WITNESSES C. D. White, E. F. Green | | 15. SIGNATURE OF DECEASED John J. Johnson | |

16. REMARKS: Death occurred at home after a brief illness. Autopsy on body only. Permission for burial granted.

17. SIGNATURE OF DECEASED: _____

18. SIGNATURE OF WITNESSES: _____

19. SIGNATURE OF PHYSICIAN: _____

20. SIGNATURE OF REGISTRAR: _____

BUREAU V. S.

AUG 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08428

CERTIFICATE OF DEATH

08426

Reg. Dist. No. 96

| | | | |
|---|------------------------|--|--------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 7005 Park Avenue | |
| 3. NAME OF DECEASED (Type or print) ALONIDAS B. COSTEN | | 4. DATE OF DEATH Month August Day 11 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-4-95 |
| 9. AGE (In years lost birthday) 61 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Leonidas J. Costen | | 14. MOTHER'S MAIDEN NAME Olivia Gertrude Cofield | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) B ronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3-5 days unknown | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 VA | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from February 12, 19 57, to August 11, 19 57, and that death occurred at 6:25 p.m. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William M. Harris M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-12-57 | |
| PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS | | Acting Director, Professional Services | |
| 22a. BURIAL, CREMATION, REMOVAL Removal | | 22b. DATE THEREOF 8-12-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY unknown Cedar Hill | | 22d. LOCATION (City, town, or county) (State) unknown/ Suffolk, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE I.O. Hill & Co. Funeral Home | | ADDRESS I.O. HILL & CO. FUNERAL HOME, Suffolk, Virginia. | |
| 24a. REC'D BY REGISTRAR DATE Aug 12, 1957 | | 24b. REGISTRAR'S SIGNATURE Irene E. Langherty | |

10/12/10

AUG 14 1957

BUREAU V. S.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08429

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08427

Reg. Dist. No. 92

| | | | | | | |
|---|-----------------------|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D. | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Fields Point | | | d. STREET ADDRESS 1 316 North | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Edwin Dennis Crouse | | | 4. DATE OF DEATH Month 8 Day 18 Year 19 57 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 22 1938 | | 9. AGE (In years last birthday) 19 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Auto Parts Co. | | 11. BIRTHPLACE (State or foreign country) Chestertown, Md. | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | |
| 13. FATHER'S NAME Herman Lee Crouse | | | 14. MOTHER'S MAIDEN NAME Dorothy Louise Joyner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO. 214-36-9473 | | | |
| 17. INFORMANT Herman L. Crouse, 316 Nst. Elkton, Md. | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in Elk River and sank in hole and never came up. | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour m. 8-18-57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elk River | | |
| 20f. (City or town) Elkton, R.D. Cecil Md. | | 20g. (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 22b. DATE THEREOF 8-22-57 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk | | | 22d. LOCATION (City, town, or county) (State) Elkton Cecil Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ralph B. Hicks, Elkton, Md. | | | 24a. REC'D BY REGISTRAR DATE 8/22/57 | | | |
| 24b. REGISTRAR'S SIGNATURE R. B. Trager | | | | | | |

RECEIVED

AUG 27 1957

BUREAU V. S.

08430

CERTIFICATE OF DEATH

Reg. Dist. No. 91

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u> | |
| c. LENGTH OF STAY IN 1b <u>35 yrs.</u> | | d. STREET ADDRESS <u>Bohemia Ave.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | | | |
|---|------------------------------|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Walter</u> Last <u>McShane</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1957</u> | | |
| 5. SEX <u>7</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5th 1880</u> | 9. AGE (In years last birthday) <u>77</u> yrs. | IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u>57</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>Benjamin Price Walters</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Rebecca Van Sant</u> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>Kathleen W. McShane</u> Address <u>Chesapeake City</u> | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC NEPHRITIS</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>592X</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>APRIL 1956</u> |
|--|--|---|

| | | |
|---|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>VARICOSE VEINS BOTH LEGS</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|---|

| | | | |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| | |
|--|--|
| 21. I certify that I attended the deceased from <u>APRIL 4</u> , 19 <u>56</u> , to <u>AUG 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>AUG 11</u> , 19 <u>57</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE <u>Henry U. Davis</u> | DATE SIGNED <u>CHESAPEAKE CITY MD 8/11/57</u> |
| PHYSICIAN'S NAME (Type) <u>HENRY U. DAVIS M.D.</u> | |

| | | | |
|---|-------------------------------------|--|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>8/14/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Bethel Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter DuBois, Jr.</u> | | 24a. REC'D BY REGISTRAR <u>Elston</u> | 24b. REGISTRAR'S SIGNATURE <u>Mrs. L. H. Hays</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| <p>1. NAME OF DECEASED <i>John Doe</i></p> | | <p>2. SEX <i>Male</i></p> | | <p>3. AGE <i>45</i></p> | |
| <p>4. DATE OF DEATH <i>Aug 18 1957</i></p> | | <p>5. TIME OF DEATH <i>10:00 AM</i></p> | | <p>6. PLACE OF DEATH <i>Home</i></p> | |
| <p>7. CAUSE OF DEATH <i>Heart Disease</i></p> | | <p>8. MANNER OF DEATH <i>Natural</i></p> | | <p>9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p> | |
| <p>10. SIGNATURE OF REGISTRAR <i>John Doe</i></p> | | <p>11. SIGNATURE OF WITNESS <i>John Doe</i></p> | | <p>12. SIGNATURE OF WITNESS <i>John Doe</i></p> | |

BUREAU V. S.

AUG 19 1957

RECEIVED

08418

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>V.</u> Last <u>EVERETT</u> | | | | 4. DATE OF DEATH Month <u>AUG.</u> Day <u>25</u> Year <u>1957</u> | | | |
| 5. SEX <u>F.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>DEC. 24, 1883</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>CHARLES BENSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MOLLIE COX</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> If yes, give war or dates of service <u>—</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | |
| 17. INFORMANT <u>MR. SAMUEL EVERETT</u> | | | | Address <u>CECILTON, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Paralysis</u> <u>381X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>massive Cerebro-vascular Accident</u> DUE TO (c) <u>Severe Hypertension</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>6 hours.</u> <u>4-5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>51</u> , to <u>Aug 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u> DATE SIGNED <u>28 Aug 57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Wallace Oberkain</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>AUG. 27, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MASSEY CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>MASSEY MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellows, Millington, MD.</u> | | | | 24. REGD. NO. <u>291551</u> | | 25. REGISTRAR'S SIGNATURE <u>J. R. Fryer</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Form No. 1

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | | 4. DATE OF BIRTH <i>Jan 15 1912</i> | |
| 5. PLACE OF BIRTH <i>John Doe</i> | | 6. OCCUPATION <i>Teacher</i> | | 7. MARITAL STATUS <i>Married</i> | | 8. DATE OF MARRIAGE <i>Jan 15 1940</i> | |
| 9. PLACE OF DEATH <i>John Doe</i> | | 10. CAUSE OF DEATH <i>Heart Disease</i> | | 11. MANNER OF DEATH <i>Natural</i> | | 12. DATE OF DEATH <i>Aug 29 1957</i> | |
| 13. SIGNATURE OF PHYSICIAN <i>John Doe</i> | | 14. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 15. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 16. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 17. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 18. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 19. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 20. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 21. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 22. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 23. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 24. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 25. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 26. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 27. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 28. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 29. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 30. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 31. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 32. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 33. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 34. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 35. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 36. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 37. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 38. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 39. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 40. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 41. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 42. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 43. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 44. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 45. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 46. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 47. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 48. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 49. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 50. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 51. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 52. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 53. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 54. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 55. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 56. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 57. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 58. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 59. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 60. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 61. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 62. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 63. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 64. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 65. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 66. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 67. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 68. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 69. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 70. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 71. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 72. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 73. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 74. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 75. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 76. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 77. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 78. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 79. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 80. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 81. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 82. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 83. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 84. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 85. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 86. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 87. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 88. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 89. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 90. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 91. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 92. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 93. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 94. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 95. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 96. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |
| 97. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 98. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 99. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | | 100. SIGNATURE OF DEATH CERTIFICATE <i>John Doe</i> | |

RECEIVED
AUG 29 1957
BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 92

08430

| | | | | | | | | |
|---|------------------------------|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Rural | | c. LENGTH OF STAY IN 1b 12 yrs. LIFE x2 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.3. | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bonnie Sue Fink | | | 4. DATE OF DEATH Month Day Year 8 30 57 | | | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-17-57 | | 9. AGE (In years last birthday) yrs. 2 Months 13 Days 13 Hours 13 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Elkton, Md. | | | | |
| 13. FATHER'S NAME Alfred Cecil Fink | | | | 14. MOTHER'S MAIDEN NAME Edna Marie Caldwell | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Address Alfred C. Fink, Elkton, R.D.3. Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion with laceration of nostril left. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 902.0 DUE TO (c) --- | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --- | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> --- | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed when left alone | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 1:30 a.m. 830 1957 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) (County) (State) Elkton Cecil Md. | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE R.C. Dodson | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| EXAMINER'S NAME (Type) R.C. Dodson | | | | | | DATE SIGNED 8-31-57 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept 1, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY BLAKE CEMETERY | | 22d. LOCATION (City, town, or county) (State) BLAKE Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Ryan | | | ADDRESS Elkton, Md. | | 24a. REC'D BY REGISTRAR DATE 9/1/57 | | 24b. REGISTRAR'S SIGNATURE J.R. Frazer | |

2065284XV4

RECEIVED

SEP 4 1957

BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08419

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08431

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | | c. LENGTH OF STAY IN 1b 2 1/2 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Elkton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | | | d. STREET ADDRESS R. F. D. # 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First RAYMOND Middle W Last FREELAND | | | | 4. DATE OF DEATH Month 8 Day 2 Year 1957 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-9-1887 | |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Con. Ret. | | | | 10b. KIND OF BUSINESS OR INDUSTRY C&NW RY | | 11. BIRTHPLACE (State or foreign country) Illinois | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME No Information | | | | 14. MOTHER'S MAIDEN NAME No Information | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Address Katharine Freeland, R.D. 1 Elkton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X GUNSHOT WOUND OF CHEST DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Paul F. Guerin | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) PAUL F. GUERIN | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 8-5-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Chicago | | 22d. LOCATION (City, town, or county) (State) Chicago Ill. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Robbins | | | | 24a. REC'D BY REGISTRAR 8/6/57 | | 24b. REGISTRAR'S SIGNATURE J. H. Frazer | |

MEDICAL CERTIFICATION

MAKING STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

AUG 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **084322**

| | | | | | | | |
|--|---------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. 4</u> | | c. LENGTH OF STAY IN 1b <u>all life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. 4 X2</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS <u>1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Everett</u> Middle <u>Le Roy</u> Last <u>Hall</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>19 57</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-30-1900</u> | | 9. AGE (In years last birthday) <u>57</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> | | | |
| 13. FATHER'S NAME <u>Wilmer J. Hall</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Tweed</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-05-3994</u> | | 17. INFORMANT <u>Mrs. Marie Hall</u> , <u>Elkton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (c), stating the underlying cause lost. DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>R.C. Dodson</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>8-14-57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8-17-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill</u> | | | |
| 22d. LOCATION (City, town, or county) <u>Elkton, R.D.</u> | | (State) <u>Md.</u> | | 24a. REC'D BY REGISTRAR <u>8/16/57</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray E. Hicks, Elkton, Md.</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>FRJ rager</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08420

Item 8 Film 220 9-6-57 et

CERTIFICATE OF DEATH

08433

Reg. Dist. No.

| | | | |
|--|------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 W Main | | d. STREET ADDRESS 207 W Main | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle D. Last HOLSTEN | | 4. DATE OF DEATH August 25 1957 | |
| 5. SEX M | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1875 March 4, 1874 |
| 9. AGE (In years last birthday) 82 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Wilmington, Del. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John W. Holsten | | 14. MOTHER'S MAIDEN NAME Margaret Ann Cook | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT 207 W Main St. Kena H. Holsten Elkton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized Arteriosclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 22, 1957, to Aug 25, 1957, that I last saw the deceased alive on Aug 24, 1957, and that death occurred at 2:00 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Milford H. Sprecher M.D. | | ADDRESS (Street, city or town, state) Elkton, Maryland | |
| DATE SIGNED Aug 27 | | | |
| PHYSICIAN'S NAME (Type) MILFORD H. SPRECHER | | Elkton, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-28-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Kemblesville Medt. | | 22d. LOCATION (City, town, or county) (State) Kemblesville Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. Henry Pippin | | ADDRESS Elkton Md. | |
| 24a. REC'D BY REGISTRAR DATE 8/28/57 | | 24b. REGISTRAR'S SIGNATURE JRB | |

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|------------------|--|--------------------|--|
| PLACE OF DEATH RESIDENT | | DATE | | HOURS | |
| 1957 | | AUG 30 | | 10:30 | |
| DECEASED | | SEX | | AGE | |
| Male | | Male | | 45 | |
| RACE | | EDUCATION | | OCCUPATION | |
| White | | High School | | Teacher | |
| MARRIAGE | | SPOUSE | | CAUSE OF DEATH | |
| Married | | Married | | Heart Disease | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | |
| None | | None | | None | |
| PLACE OF BIRTH | | PLACE OF DEATH | | DATE OF DEATH | |
| Baltimore, Md. | | Baltimore, Md. | | Aug 30, 1957 | |
| MOTHER'S NAME | | FATHER'S NAME | | DECEASED'S NAME | |
| Mary Jane Smith | | John Doe | | John Doe | |
| MOTHER'S ADDRESS | | FATHER'S ADDRESS | | DECEASED'S ADDRESS | |
| 123 Main St. | | 456 Main St. | | 789 Main St. | |
| CITY | | CITY | | CITY | |
| Baltimore | | Baltimore | | Baltimore | |
| STATE | | STATE | | STATE | |
| Md. | | Md. | | Md. | |
| COUNTRY | | COUNTRY | | COUNTRY | |
| U.S.A. | | U.S.A. | | U.S.A. | |
| MARRIAGE | | SPOUSE | | CAUSE OF DEATH | |
| Married | | Married | | Heart Disease | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | |
| None | | None | | None | |
| PLACE OF BIRTH | | PLACE OF DEATH | | DATE OF DEATH | |
| Baltimore, Md. | | Baltimore, Md. | | Aug 30, 1957 | |
| MOTHER'S NAME | | FATHER'S NAME | | DECEASED'S NAME | |
| Mary Jane Smith | | John Doe | | John Doe | |
| MOTHER'S ADDRESS | | FATHER'S ADDRESS | | DECEASED'S ADDRESS | |
| 123 Main St. | | 456 Main St. | | 789 Main St. | |
| CITY | | CITY | | CITY | |
| Baltimore | | Baltimore | | Baltimore | |
| STATE | | STATE | | STATE | |
| Md. | | Md. | | Md. | |
| COUNTRY | | COUNTRY | | COUNTRY | |
| U.S.A. | | U.S.A. | | U.S.A. | |

BUREAU V. 8

AUG 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08434

Reg. Dist. No. 92

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Cecil Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.4 | | c. LENGTH OF STAY IN 1b 36 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fairhill | | d. STREET ADDRESS Fairhill | |
| 3. NAME OF DECEASED (Type or print) First Paul Middle Hubis Last 4. DATE OF DEATH Month 8 Day 18 Year 1957 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-2-1916 |
| 9. AGE (In years last birthday) 41 yrs. | | IF UNDER 1 YEAR Months 41 Days 18 Hours 19 Min. 57 | IF UNDER 24 HRS. Months 41 Days 18 Hours 19 Min. 57 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY R.R. | |
| 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Nicholas Hubis | | 14. MOTHER'S MAIDEN NAME Mary Leano | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 716-01-8341 | |
| 17. INFORMANT Steve Hubis, Rising Sun, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot in abdomen ar ensiform Cartilage 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 976X DUE TO (c) 976X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 976X INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 12 gauge shot gun. | |
| 20c. TIME OF INJURY Month, Day, Year Hour 1:10 o. m. 8-18-57 p. m. | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Elkton, R.D.4. Cecil Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE R.C. Dodson | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) R.C. Dodson | | DATE SIGNED 8-19-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-21-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Sarps Cemetery | | 22d. LOCATION (City, town, or county) (State) Elkton R.D. Cecil Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, Elkton, Md. | | 24b. REGISTRAR'S SIGNATURE JR Frazier | |
| 24a. REC'D BY REGISTRAR DATE 8/21/57 | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-------------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| Date of Death | | Time of Death | | Place of Death | |
| Cause of Death | | Manner of Death | | Occupation | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| Date of Report | | Time of Report | | Place of Report | |

RECEIVED
JUG 28 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08434

CERTIFICATE OF DEATH

Reg. Dist. No. 96

08435

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland | | c. LENGTH OF STAY IN 1b 1 day | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre DeGrace, Maryland 1224, 2 | | d. STREET ADDRESS 119 Deaver Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First PHILIP Middle L. Last KEPPINGER | | 4. DATE OF DEATH Month August Day 4 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 22, 1933 |
| 9. AGE (In years lost birthday) 24 yrs. | | IF UNDER 1 YEAR Months 24 Days 24 Hours 24 Min. | IF UNDER 24 HRS. Months 24 Days 24 Hours 24 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installer | | 10b. KIND OF BUSINESS OR INDUSTRY Telephone Co. | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Matthew Keppinger | | 14. MOTHER'S MAIDEN NAME Olivia Riale | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Korean | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIO PNEUMONIA, BILATERAL, UNRESOLVED DUE TO 193X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRAIN TUMOR, RIGHT PARIETAL LOBE, MALIGNANT. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 To 8 Hours Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1491X | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 3, 1957 , to August 4, 1957 , that cause of death was BRONCHIO PNEUMONIA, BILATERAL, UNRESOLVED and that death occurred at 12:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Perry Point, Md. DATE SIGNED 8-4-57 | | | |
| ACTUAL SIGNATURE E. S. Ellis | | PHYSICIAN'S NAME (Type) E. S. ELLIS, M.D., Acting Director, Professional Services, VA Hospital | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-4-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY West Nottingham | | 22d. LOCATION (City, town, or county) (State) Nottingham, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son | | 24a. REC'D BY REGISTRAR 8-5-57 | |
| 24b. REGISTRAR'S SIGNATURE Innocent E. Dougherty | | 24c. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

1957

| | | | |
|---------------------------------------|--|--|--|
| Name of Deceased [Illegible] | | Sex [Illegible] | |
| Date of Birth [Illegible] | | Place of Birth [Illegible] | |
| Date of Death [Illegible] | | Place of Death [Illegible] | |
| Cause of Death [Illegible] | | Manner of Death [Illegible] | |
| Physician's Name [Illegible] | | Hospital Name [Illegible] | |
| Address of Deceased [Illegible] | | Address of Place of Death [Illegible] | |
| Signature of Physician [Illegible] | | Signature of Registrar [Illegible] | |

BUREAU V. 2

AUG 7 1957

RECEIVED

5, 2, 1, 16, 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08436

08435

CERTIFICATE OF DEATH

Reg. Dist. No. 96

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Atlantic</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point,</u> | | | | c. LENGTH OF STAY IN 1b <u>24 days</u> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u> | | | | d. STREET ADDRESS <u>355 North Annapolis Avenue</u> | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>J.</u> Last <u>LONERGAN</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1957</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>February 1, 1906</u> | | | |
| 9. AGE (In years lost birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Parking Meters</u> | | 11. BIRTHPLACE (State or foreign country) <u>Phila., Pa.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | | | |
| 13. FATHER'S NAME <u>THOMAS E. LONERGAN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ALICE FINIGAN</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | (If yes, give war or dates of service) <u>WW-II</u> | | 16. SOCIAL SECURITY NO. <u>150 09 7069</u> | | 17. INFORMANT <u>Hosp. Records, VA Hospital, Perry Point, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the left temporal parietal</u> <u>199.9</u> DUE TO <u>region with hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) <u> </u> | | | | 20g. (County) <u> </u> | | 20h. (State) <u> </u> | | | |
| 21. I certify that <u>VA</u> attended the deceased from <u>July 18, 1957</u> to <u>August 11, 1957</u> . <u>last lost on the deceased</u> <u>live on</u> and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Perry Point, Md.</u> DATE SIGNED <u>8-12-57</u> | | | | | | | | | |
| ACTUAL SIGNATURE <u>William M. Harris</u> | | | | M.D. <u>VAH, Perry Point, Md.</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>WILLIAM M. HARRIS</u> | | | | Acting Director, Professional Services | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>8-12-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Penna.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>PENNINGTON & SON,</u> | | | | ADDRESS <u>Havre DeGrace, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>8-12-57</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u> | | | | | | | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-------------------|--|---------------------|--|----------------|--|---------------|--|----------------|--|---------------------|--|------------------------|--|-----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES E. LAMARCA | | Male | | 45 | | 1912 | | New York | | New York | | New York | | New York | |
| RACE | | COLOR | | RELIGION | | MARRIAGE | | EDUCATION | | OCCUPATION | | PREVIOUS ILLNESS | | CAUSE OF DEATH | |
| White | | White | | Roman Catholic | | Married | | High School | | Teacher | | None | | Heart Disease | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | MANNER OF DEATH | | CERTIFICATE OF DEATH | | SIGNATURE OF DECEASED | |
| August 14, 1957 | | Home | | Baltimore | | Maryland | | United States | | Natural | | JAMES E. LAMARCA | | | |
| DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY | | STATE | | COUNTRY | | MANNER OF INTERMENT | | SIGNATURE OF INTERMENT | | SIGNATURE OF DECEASED | |
| August 16, 1957 | | St. Mary's Cemetery | | Baltimore | | Maryland | | United States | | Burial | | JAMES E. LAMARCA | | | |
| DATE OF BURIAL | | PLACE OF BURIAL | | CITY | | STATE | | COUNTRY | | MANNER OF BURIAL | | SIGNATURE OF BURIAL | | SIGNATURE OF DECEASED | |
| August 16, 1957 | | St. Mary's Cemetery | | Baltimore | | Maryland | | United States | | Burial | | JAMES E. LAMARCA | | | |

UREAU V. S.

AUG 14 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08436

CERTIFICATE OF DEATH

08437

Reg. Dist. No. 96

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 6yrs.3mo.8days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 1228 Blair Mills Road | |
| 3. NAME OF DECEASED (Type or print) First JONAS Middle G. Last MANNES | | 4. DATE OF DEATH Month August Day 6 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-30-95 |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Isidore Mannes | |
| 14. MOTHER'S MAIDEN NAME Betty Goldsmith | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | |
| 16. SOCIAL SECURITY NO. 220-30-6645 | | 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of the heart due to infarction DUE TO (c) Arteriosclerotic heart disease, severe | | | INTERVAL BETWEEN ONSET AND DEATH 3 - 5 minutes Approx. 3 weeks unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 29 , 19 51 , to August 6 , 19 57 , and that death occurred at 11:18a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 8-7-57 | | | |
| ACTUAL SIGNATURE William M. Harris | | PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS Acting Director, Professional Services | |
| 22a. BURIAL, CREMATION, or other final disposition Removal | 22b. DATE THEREOF 8-7-57 | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | 22d. LOCATION (City, town, or county) (State) Arlington, Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Fub. Home, 4217-9th St. Wash. D.C. | | 24a. REC'D BY REGISTRAR DATE AUG 9 1957 | 24b. REGISTRAR'S SIGNATURE Herbert Daugherty |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Willm 219 8-30-57 et

08421

CERTIFICATE OF DEATH

08438

Reg. Dist. No. 92

| | | | |
|--|--------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside Heights, Newark Del 46 x 5 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | d. STREET ADDRESS 214 Brown Leaf Rd | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ellen M. Mc Ivor | | 4. DATE OF DEATH Month Day Year Aug 22 19 57 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1878 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Iron work | 9. AGE (In years lost birthday) 79 yrs. |
| 11. BIRTHPLACE (State or foreign country) Canada | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Nowe | | 14. MOTHER'S MAIDEN NAME Martha Brophy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17. INFORMANT Gertrude Finney 214 Brown Leaf Rd Hillside Hgts. Newark Del | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 Aspiration Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute dilatation of stomach DUE TO (c) Intestinal Obstruction - Cause Undet | | INTERVAL BETWEEN ONSET AND DEATH 24 hr 24 hr 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction - old | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 20 AUG. 1957, to 22 AUG. 1957, that I last saw the deceased alive on 21 AUG. 1957, and that death occurred at 1:22 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Willford Eppes | | ADDRESS (Street, city or town, state) 325 E. Main St Newark, Del. | |
| PHYSICIAN'S NAME (Type) Willford Eppes | | DATE SIGNED 8-22-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 8-22-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Elkton Md. | | 22d. LOCATION (City, town, or county) (State) Philadelphia Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pappin | | 24a. REC'D BY REGISTRAR DATE 8/24/57 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE H. Frazer | |

JUN 27 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08422

CERTIFICATE OF DEATH

08439

Reg. Dist. No. 92

| | | | |
|---|------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural Elkton, Md. | |
| c. LENGTH OF STAY IN 1b 24 hrs | | d. STREET ADDRESS 1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ROBERT PHILIP MULLEN | | 4. DATE OF DEATH Month Day Year August 3, 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 16, 1896 |
| 9. AGE (In years lost birthday) 61 yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Bainbridge NTC | |
| 11. BIRTHPLACE (State or foreign country) Cecil Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Dennis Mullen | | 14. MOTHER'S MAIDEN NAME Elizabeth Louth | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W.W. L 212 32 4605 | |
| 17. INFORMANT Anthony F. Mullen | | Address Elkton RFD #2 Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 24 hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 2, 1957, to Aug. 3, 1957, that I last saw the deceased alive on Aug. 2, 1957, and that death occurred at 1 A. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE S. Ralph Andrews, Jr. | | ADDRESS (Street, city or town, state) 233 E. Main Street | |
| PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr. | | DATE SIGNED 8/3/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-6-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Catholic | | 22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry Pappas | | 24a. REC'D BY REGISTRAR DATE 8/6/57 | |
| ADDRESS Elkton, Md. | | 24b. REGISTRAR'S SIGNATURE FR Frazer | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

AUG 7 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The following copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08440

Reg. Dist. No. 92

08423

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY Cecil | MARYLAND | STATE Maryland | COUNTY Cecil |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Elkton | LENGTH OF STAY (In this place) 17 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 Booth St. | | STREET ADDRESS (If rural give location) 121 Booth, Street | |
| 3. NAME OF DECEASED (Type or Print) Ernest Snead | | 4. DATE OF DEATH (Month) (Day) (Year) August 10 1957 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH February 4, 1890 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Housing Project | 9. AGE last birthday 67 Yrs. |
| 11. BIRTHPLACE (State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Snead | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-14-8478 | |
| 17. INFORMANT & ADDRESS Tichie Anna Snead | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| 592x IMMEDIATE CAUSE (A) Cardiac due to Arotic Insufficiency | | | 3 Years |
| ANTECEDENT CAUSE(S) DUE TO (B) Chronic interstitial Nephritis | | | 5 Years |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Gastritis | | | 4 Months |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Uremia | | | 3 Weeks |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> al work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21i. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Jan. 2, 1941, to Aug. 10, 1957, that I last saw the deceased alive on Aug. 7, 1957, and that death occurred at 1 A.M. from the causes and on the date stated above. | | | |
| SIGNATURE James L. Johnson | | DATE SIGNED Aug. 8/10/57 | |
| ADDRESS (Street, city, town, state) M.D. 245 East High, St. Elkton, Md. | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8/12/57 | NAME OF CEMETERY OR CREMATORY Providence Cem. | LOCATION (City, town, or county) (State) Elkton Md |
| 24. REC'D BY REGISTRAR 8/12/57 | REGISTRAR'S SIGNATURE F. R. Frazer | 25. FUNERAL DIRECTOR'S SIGNATURE H. W. Wetherill | ADDRESS Elkton Md |

CERTIFICATE OF DEATH

Form No. 10

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF PHYSICIAN
DATE

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ROOM

DATE

TIME

PLACE

CAUSE

MANNER

SIGNATURE

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08441

08437

CERTIFICATE OF DEATH

Reg. Dist. No.

96

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Perryville, Rural | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frenchtown | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Georgeanna Middle Thompson Last Thompson | | | | 4. DATE OF DEATH Month Aug. Day 27 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 26, 1878 | |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months 8 Days 27 | | IF UNDER 24 HRS. Hours 2 Min. 00 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME Henry Jackson | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Anne Pennington | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Samuel C. Thompson, Perryville, Md. | | | |
| 17. INFORMANT Samuel C. Thompson, Perryville, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Diabetes | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours 8 yrs - | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Port Deposit, Md. | | | | 20g. (County) Port Deposit, Md. | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from Aug 25, 1957 to Aug 25, 1957 , that I last saw the deceased alive on Aug 25, 1957 , and that death occurred at 2:29 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Clarence I. Benson M.D. | | | | ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 8/28/57 | | | |
| PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMAINS (Specify) Burial | | 22b. DATE THEREOF 8-29-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Asbury | | 22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son | | | | ADDRESS Perryville, Md. | | 24a. REC'D BY REGISTRAR DATE 8/29/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Inez E. Daugherty | | | |

SEP 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08438

CERTIFICATE OF DEATH

Reg. Dist. No.

08442

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 7yrs.17days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27 0354.2 | |
| f. STREET ADDRESS 4400 Washington Blvd. | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ELMER Middle OAKLAND Last TOWNSEND | | 4. DATE OF DEATH Month August Day 25 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 14, 1873 |
| 9. AGE (In years last birthday) 84 yrs | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jacob Townsend | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with cardiac insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general - unknown | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. VA 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug. 8th, 19 50 , to Aug. 25th, 19 57 , and that death occurred at 8:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE E. S. Ellis | | DATE SIGNED V.A. Hospital, Perry Point, Md. 8-26-57 | |
| PHYSICIAN'S NAME (Type) E. S. Ellis, M.D., | | Actg. Director, Professional Services. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 8-26-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Paul | | 22d. LOCATION (City, town, or county) (State) Marion, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & CO. FUNERAL HOMES, Salisbury, Md. | | ADDRESS Salisbury, Md. | |
| 24a. REC'D BY REGISTRAR DATE 8-26-57 | | 24b. REGISTRAR'S SIGNATURE James E. Dougherty | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|-----------------------|--|-------------------|--|---------------------------------|--|-------------------------|--|---------------------|--|------------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Date of death | | 6. Place of death | | 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | | 10. Signature of registrar | |
| Perry, Henry | | Male | | 45 | | 1912 | | 1957 | | Home | | Heart Disease | | Natural | | [Signature] | | [Signature] | |
| 11. Name of informant | | 12. Relationship | | 13. Address | | 14. City | | 15. State | | 16. Zip | | 17. Date of report | | 18. Signature of informant | | 19. Signature of registrar | | 20. Signature of physician | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 21. Name of hospital | | 22. Name of physician | | 23. Name of nurse | | 24. Name of attending physician | | 25. Name of pathologist | | 26. Name of coroner | | 27. Name of medical examiner | | 28. Name of funeral home | | 29. Name of cemetery | | 30. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 31. Name of registrar | | 32. Name of physician | | 33. Name of nurse | | 34. Name of attending physician | | 35. Name of pathologist | | 36. Name of coroner | | 37. Name of medical examiner | | 38. Name of funeral home | | 39. Name of cemetery | | 40. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 41. Name of registrar | | 42. Name of physician | | 43. Name of nurse | | 44. Name of attending physician | | 45. Name of pathologist | | 46. Name of coroner | | 47. Name of medical examiner | | 48. Name of funeral home | | 49. Name of cemetery | | 50. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 51. Name of registrar | | 52. Name of physician | | 53. Name of nurse | | 54. Name of attending physician | | 55. Name of pathologist | | 56. Name of coroner | | 57. Name of medical examiner | | 58. Name of funeral home | | 59. Name of cemetery | | 60. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 61. Name of registrar | | 62. Name of physician | | 63. Name of nurse | | 64. Name of attending physician | | 65. Name of pathologist | | 66. Name of coroner | | 67. Name of medical examiner | | 68. Name of funeral home | | 69. Name of cemetery | | 70. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 71. Name of registrar | | 72. Name of physician | | 73. Name of nurse | | 74. Name of attending physician | | 75. Name of pathologist | | 76. Name of coroner | | 77. Name of medical examiner | | 78. Name of funeral home | | 79. Name of cemetery | | 80. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 81. Name of registrar | | 82. Name of physician | | 83. Name of nurse | | 84. Name of attending physician | | 85. Name of pathologist | | 86. Name of coroner | | 87. Name of medical examiner | | 88. Name of funeral home | | 89. Name of cemetery | | 90. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| 91. Name of registrar | | 92. Name of physician | | 93. Name of nurse | | 94. Name of attending physician | | 95. Name of pathologist | | 96. Name of coroner | | 97. Name of medical examiner | | 98. Name of funeral home | | 99. Name of cemetery | | 100. Name of burial place | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

RECEIVED
BUREAU V. 21
JUN 27 1957